

Gonorrhea and syphilis are reportable diseases in all states. All states require a morbidity report from providers when they diagnose or treat a patient with gonorrhea or syphilis. Most states also require reports from laboratories when a laboratory test suggests direct or indirect evidence of acute or untreated sexually transmitted infection. Provider and laboratory reports are processed by local health departments where morbidity data are recorded and also passed on to the state level. Periodically, states send aggregate STD morbidity reports or summary reports without personal identifiers to CDC where national data are analyzed.

Chlamydia is a widely prevalent STD and state and local programs are in the early stages of organizing chlamydia prevention programs. Approximately 42 states require reporting of chlamydia infection. Chlamydia surveillance is in the developmental stages in the U.S. and accurate trend data are available only in selected areas. Planning groups are encouraged to use these data when they are available in local areas.

Target population: All persons diagnosed with gonorrhea, chlamydia, or syphilis in the U.S.

Strengths: Gonorrhea and syphilis data are widely available at the local level and can help describe specific populations in a community where most of the individuals are not HIV infected but who are at considerable risk because of their sexual behaviors and their acute disease status. Considering the relatively short incubation periods for these infections, gonorrhea and syphilis morbidity represent recent consequences of unsafe sexual behavior and point to populations who are potentially at very high risk for acquiring and transmitting HIV infection. Sufficient evidence has accumulated to suggest that the presence of genital ulceration or acute infection of the urethra or cervix actually facilitates the spread of HIV infection when the virus is present. Therefore, identifying and treating persons with acute STDs is an important strategy to consider when communities wish to lower the probability that an infected individual will transmit HIV infection or that an uninfected person will acquire it. Rapid, steady changes (increases or decreases) in STD rates are often a sensitive sign of changing community norms or the introduction of new transmission co-factors in the community.

Limitations: STDs are underreported in all areas. The degree of underreporting varies from community to community. In general, reporting is considered more complete from public clinics and laboratories than from their private-sector counterparts. Therefore, STD community profiles are more likely to reflect the characteristics of persons who receive care at publicly-funded facilities. Missing age, gender, race/ethnicity, and geographic descriptors on local case reports often result in underestimating the impact of disease in the community and limit the ability of analysts to distinguish and target specific subpopulations and their neighborhoods for prevention services.

4.2.1.11 Data from HIV Counseling and Testing Programs. All states and territories (and some local jurisdictions) have entered into cooperative agreements with, and receive funds from, CDC to provide a variety of HIV/AIDS prevention services in their areas. Part of these funds are used to support HIV counseling and testing services.

Stated Objectives and Overview. The HIV Counseling and Testing System (HIV CTS) is an information system used to quantify HIV counseling and testing services delivered in publicly-funded sites and to determine the characteristics of persons receiving those services. These data are used by prevention programs to plan and target services for high-risk individuals.

Two types of HIV counseling and testing data are available. In 41 areas, a standardized abstract of each counseling and testing interaction is prepared at the testing site and forwarded to a central health department office where a centralized data base is maintained. The following data are collected on the abstract form: Name of the area receiving funds, counseling and testing site type and site identification number, date of visit, demographic variables (gender, age, race/ethnicity, state, county, zip code), health insurance provider, reason for visit, risk factors, previous HIV test and results (client elicited), whether testing was anonymous or confidential, test result, date and results of post-test counseling. No personal identifiers are collected on the abstract form.

In 24 areas, all publicly-funded sites periodically compile a standardized aggregate summary of the services provided in their setting. Aggregate summary data are also forwarded to a central health department office where the data base is maintained. These aggregate reports include name of the area receiving funds, calendar quarter in which services were delivered, number tested and number positive for each risk group, number tested, number positive, and number post-test counseled by type of test site, and number tested and number positive by race/ethnicity, gender, and age group.